DOCUMENT RESUME

ED 450 916 PS 029 258

TITLE	ACCESS to Comprehensive School-Based Health Services for Children and Youth, 2000-2001.
INSTITUTION	George Washington Univ., Washington, DC. School of Public Health and Health Services.
PUB DATE	2000-00-00
NOTE	32p.; Winter 2001 is the final issue of "ACCESS." For 1999 issues, see PS 029 221. Edited by Burness Communications. Making the Grade is a national grant program supported by The Robert Wood Johnson Foundation.
AVAILABLE FROM	Center for Health and Health Care in Schools, George Washington University, School of Public Health and Health Services, 1350 Connecticut Avenue, NW #505, Washington, DC 20036; Tel: 202-466-3396; Fax: 202-466-3467; Web site: http://www.healthinschools.org.
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	ACCESS; Spr 2000-Win 2001
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	*Child Health; Elementary Secondary Education; Nontraditional Education; Organizational Communication; Program Descriptions; Program Termination; Public Policy; *School Health Services; Student Attitudes
IDENTIFIERS	Continuous Quality Improvement; *School Based Health Clinics; School Based Services

ABSTRACT

This document consists of four consecutive issues of a newsletter presenting information on public policy and research of interest to school-based health centers (SBHCs) for children and youth. The spring 2000 issue explores why some SBHCs are closing and student support for SBHCs. The summer 2000 issue addresses the use of SBHCs in alternative schools and also presents data from a national census of SBHCs. The fall 2000 issue provides advice to SBHCs on creating a compelling message and addressing opposition. The winter 2001 issue (the final issue of the newsletter) describes the launch of the Center for Health and Health Care in Schools, which replaces Making the Grade, the national grant program to establish new SBHCs through state and local partnerships. This issue contains parting words from Making the Grade grantees, along with a special insert on continuous quality improvement in SBHCs. (EV)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 450 916

ACCESS to Comprehensive School-Based Health Services for Children and Youth, 2000-2001

Spring 2000-Winter 2001

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

J. Lear

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

1

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PS 029 258

BEST COPY AVAILABLE

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

Why Are Some School-Based Health Centers Closing?

Sometimes, vibrant and successful school-based health centers close down despite the best efforts of staff and administrators. In an attempt to understand how and why this happens, ACCESS spoke to former staff and others involved with four school-based health centers that have closed or are closing.

While it is difficult to draw general conclusions based on the experiences of four centers, two related threads run through their stories. The centers all experienced, and were unable to overcome, serious financial hurdles that, when combined with other complications, resulted in closure. And all four could have benefited tremendously—possibly to the point of recovering from their financial difficulties—from a broader base of support from the school, the community, and from their sponsoring organizations.

The Balancing Act

Like all health care provider organizations today, even successful school-based health centers face uncertainty when it comes to establishing and maintaining stable funding. Historically, the centers have been supported largely by grants from public and private sources. Today, in addition to grants, centers often are supported by sponsoring organizations, such as hospitals or community health centers, and are relying more on reimbursement from third-party payers for a portion—albeit usually a small portion—of their budget. Relying on multiple funding sources to cover costs year after year seems to be where many centers run into trouble. For a number of centers, financial viability has become even more difficult since the emergence of Medicaid managed care.

"Our clinic really started deteriorating when managed care came along and we were no longer able to bill Medicaid for services," said Leslie Morris, former director of the Adolescent Health Clinic at Snyder High School in Jersey City, New Jersey. In 1995, the Jersey City Family Health Center, a community health center (CHC) which sponsored Snyder since its opening in 1988, pulled all primary care services out of the

Continued on next page

Inside This Issue

• Students Rally Around School-Based Health Centers

PS 029258

Students Rally Around School-Based Health Centers

San Francisco high school students chat with mayoral candidate and city Board of Supervisors President Tom Ammiano about his support for school-based health centers during a question-and-answer session prior to the November 1999 election. Story begins on page 3.

Photo: Courtesy of San Francisco Examiner

Continued from page 1

student center because it could no longer bill Medicaid separately for those services. Under Medicaid managed care, the CHC received capitated primary care payments and decided that sharing this limited payment with Snyder was unworkable. In prior years, Medicaid reimbursements had accounted for approximately 20 percent of the center's budget. According to Morris, the loss of primary care services caused patient visits to the center to plummet from an estimated 5,000 to 900 a year (there are 1,200 students in the school and prior to the loss of services, about 70% were enrolled in the center. That percentage has been steadily declining since then).

But Medicaid managed care was just the beginning of a very difficult time for the school-based health center, explained Morris. Around the same time, the center's grant support from the Robert Wood Johnson Foundation also expired, and soon after the school-based health center went through a difficult transition to a new sponsoring organization. Today, even though the center has not officially closed, Morris describes it as "totally dead"—there are few on-site services and providers left, and students who once used the center now go to the local emergency room when they're sick.

"If the organization that funds your school-based health center doesn't truly 'get it,' or if the school isn't 100% enthusiastic, or if parents don't know what you're trying to do, then you have to work hard to help them get it. Otherwise, if your center ever gets in trouble, those people aren't going to say 'Let's help fix the problem,' they're going to say 'Oh, just close it down."

Leslie Morris

In Las Cruces, New Mexico, Onate High School was one of five area schools that lost its health center when its parent agency, Comprehensive School Health, gave up sponsorship of five school-based health centers due to a funding shortfall. In school year 1996-97, Onate served 28 percent of the school's approximately 1,500 students and logged an estimated 2,300 patient visits. Two factors led to the shortfall. When the state switched from Medicaid fee-for-service to managed care, Comprehensive School Health was unable to contract as a health plan network provider, and lost its ability to bill Medicaid. At the same time, another state-funded program that covered uninsured children—Healthier Kids—lost its funding. "So there went two important pay sources down the tubes," said Beverly Hine, RN, MPH, coordinator of school health services for Las Cruces Public Schools.

Medicaid fee-for-service payments comprised about one-third of the school-based health center funding, said Hine. Healthier Kids funding accounted for about 20 percent of the center's operating budget in school year 1997-98, according to Comprehensive School Health.

As with the Snyder school-based health center in New Jersey, the Onate center—which operated from 1996 to 1999—struggled with multiple financial difficulties. The school district tried to save the city's five centers by seeking other sponsoring organizations, and while some of the centers were saved, no organization came forward to sponsor Onate. Today, the school district is still seeking a sponsor for Onate, and it also participates in a statewide advisory group that is exploring ways to make contracts between centers and health plans a reality so that centers can bill for their Medicaid and CHIP enrollees.

While financial difficulties may be an obvious symptom that a center is in serious trouble, there are other factors that make each story much more complex. Notably, the school-based health centers profiled here do not appear to have had the level of community support needed to weather a serious budget crisis. "It's important not to lay too much blame [for a center's difficulties] at the feet of Medicaid managed care," said John Schlitt, director of the National Assembly on School-Based Health Care, "because Medicaid wasn't a vital revenue source for many centers before managed care came along. School-based health centers have always had to deal with funding issues—whether related to Medicaid or not—so clearly there are other issues besides finances to look at when you talk about what makes or breaks a center. For example, strong community support is vital to any center's success."

The Importance of Community Support

According to those interviewed for this article, a school-based health center can never have too much support—from students, teachers, the school and school district, community funding organizations, other providers, public officials and other local leaders. Most of those interviewed for this article suggested that a broader, stronger foundation of support could have meant a very different outcome for their school-based health centers.

Rea Katz, PA-C, MS, who served as director and full-time nurse practitioner at the comprehensive Wellness Center at South Division High School in Milwaukee, said that if she had it to do again, she would have tried to build more support for her center. Katz's center closed in 1998 after operating for five years under the aegis of the 16th Street Community Health Center, whose board voted to close the center due to financial difficulties. [The school-based health center reopened a few months later under new sponsorship]. At the time of its closure, approximately half of the school's 1,400 students were enrolled in the center, which tallied 1,500 patient visits a year. In talking about the Board vote to close the center Katz said, "Looking back, I would've tried to engender more support from the mother organization. I would've tried to foster better communications with the administration [of the 16th Street CHC] so that there was institutional support that went far beyond financial support."

Katz's comments were echoed by Leslie Morris: "In order for any school-based health center to survive," she said, "you have to have people outside the center who understand what you're trying to do and are committed to the concept. If the organization that funds

Continued on page 4, column 3

Students Rally Around School-Based Health Centers

When it comes to gaining public support, school-based health centers have for years faced a dilemma. The people who appear to benefit most from their services—students and families—have been silent in the political process.

But this is changing.

—In this age of consumerism in health care—when consumers' rights movements are shaping the policies of health maintenance organizations—students are beginning to speak for themselves. And—in at least two major cities—they are asking for school-based health care. In New Orleans and San Francisco, students have been instrumental in lobbying for—and winning—city funding for school-based health centers.

New Orleans: Students Lobby to Keep Their Center Open

According to former student Harry Wilson, the school-based health center at George Washington Carver High School in New Orleans is more than just a place for students to go when they don't feel well. It is a place where they can go and feel cared for, where their well being is the first priority, and where the adults really listen to them. "It is a home away from home," Wilson said.

It is for this reason that several students responded enthusiastically to Clint Ball, the center's public health educator, when he first approached them in 1994 to rally on behalf of the financially troubled center, which was about to lose city funding.

"I was doing things on my own—calling city councilmen, faxing them information on the center, asking them not to cut our funding," said Ball. "But I was a city employee and I was asked to stop doing these things on city time, which was fair enough. But that left us without anyone to fight for the center. So I came up with the idea of working with the students who participate in our Peer Assistants program."

The school's Peer Assistants program identifies students who have the potential to serve as peer counselors and school leaders and provides them with a variety of training opportunities to help refine their skills. Approximately 30-50 students participate in the program each year. And almost every year since 1994, their lobbying efforts on behalf of their school-based health center have been successful.

This past year the students were told that there was absolutely no money to allocate to the health department's two school-based health centers. "There seemed to be more of a budget crisis this year," said Ball. "It seemed like we were going to lose no matter what we did, so we came down hard. We brought in some of the teen moms and let them speak. They were very effective."

Ultimately, the students' perseverance paid off and the school-based health centers—which previously had received $150,000 to $180,000 in city funding through the health department—were made part of the public school budget—a change with unknown implications for future funding cycles. "I'm not sure yet if we'll have to lobby for funding within the school budget this year or not," said Ball. "But we'll be ready if we do."

"The kids get a real charge out of it," he said. "Any time you get them together and say 'let's do something to improve this situation,' they're up for it. We've tried to instill in them a sense of leadership, a sense of community responsibility, a sense that we all have to step up to the plate and help out on important issues."

Ball explained that each year, well before the city budget comes up for discussion in the summer, the students come together and discuss their advocacy strategy. "We talk about arguments that might influence the city council," he said. "We identify four or five areas that we should focus on such as the need for students who are going through trauma to have someone to talk to, the need for teenage moms to be able to return to school [the center provides on-site day care], those sorts of things. And we never forget to include the cost-effectiveness of school-based health centers in terms of reducing emergency room visits."

Once the students have identified winning arguments, they practice their presentations through role-playing exercises that help them fine-tune their oratory skills. On the day that the New Orleans City Council holds its health department budget hearing, the Carver students, whose parents have given prior permission, take a bus down to City Hall and participate in the democratic process. "We've never had a parent say 'no' to a child who has wanted to participate," said Ball. "I think most of them are proud that their kids are taking an interest and learning to stand up for themselves."

Photo: Courtesy of San Francisco Examiner

San Francisco Mayor Willie Brown participates in the question-and-answer session with city high school students prior to the city's mayoral election. Brown was re-elected for another term.

"The school-based health center has changed my life," said former student Wilson, who graduated from Carver in 1998 and now works as an administrative assistant in the school-based health center. "I started coming [to the center] in the eighth grade because I heard from my cousins that this was a place you could come and be welcomed." He eventually became director of the Peer Assistants program and was eager to take action when a budget crunch threatened the center's continuation. "Closing the center would be like closing my second home; I couldn't let it happen," Wilson said. "And the other students feel the same. If you told them the school-based health

Continued on page 4

Continued from page 3

center was closing they'd hop on the first bus down to city council chambers and try to stop them."

San Francisco: Students Win Budget Approval for Two New Centers

Rather than trying to save an existing school-based health center, students in San Francisco recently began lobbying local officials for the creation of new centers at each of the city's seven largest high schools. They have had some success, but they aren't finished yet.

In San Francisco, there are 22 public high schools, only one of which—Balboa High—has a school-based health center. And only three of the remaining 21 schools have a school nurse on campus. A school-based health center operating at Mission High was closed down in 1997 (See "Why Are Some SBHCs Closing?" in this issue). In 1998, a group of 16 students backed by Coleman Advocates for Children and Youth—a non-profit organization that trains students, parents, and others to advocate for kids—conducted a survey as part of the national Youth Vote project at 13 city high schools. The purpose of the survey was to identify the most important issues to students. Health care came out on top.

"Approximately 5,000 students were surveyed," said Taj James, director of youth development for Coleman. "We found that 67 percent of students said they'd make use of a school-based health center if one were available, and their primary reason for using the health center would be for mental health services."

These findings—combined with the closing of the popular Mission High center—spurred the group of Coleman-sponsored students, who call themselves Youth Making a Change (YMAC), to organize a lobbying effort around school-based health centers. Their goal: to convince the city to approve $1.4 million to fund school-based/school-linked health centers at the city's seven largest high schools.

The YMAC members arrived at this goal through a carefully developed process. They assessed the health care resources available to students in their neighborhoods; visited the city's only school-based health center; and met with local provider groups, community organizations, the former director of the defunct center at Mission High, and others to identify a politically viable plan that would address students' needs. Once they had their plan in place, they met with council members and other city leaders, recruited student volunteers to write and call council members and the mayor's office, prepared informational materials for the press and the public, and spoke at city council meetings.

Their efforts won them approval of a $550,000 budget for a pilot program that will create two new school-based health centers, which are slated to open this winter. But they didn't stop there. They are continuing to push for their original plan, hoping to get their $1.4 million proposal into the 2001 city budget. During the elections this past November, YMAC was able to secure a commitment to the idea from both the mayor (who was reelected) and his challenger.

"There's so much momentum right now," said James. "The students have managed to convert a lot of naysayers and have really won people over. I think most people just didn't realize that schools were providing nothing. They assumed that there was at least a school nurse. Finding out that there isn't, and finding out that students may have the greatest health needs and the least access to care really spurred people to want to fix the situation."

Making the Grade is a national grant program supported by The Robert Wood Johnson Foundation. Under this initiative, the Foundation has funded nine states to establish school-based health centers in local communities and to create state and local policies that support comprehensive care for children and adolescents.

• • •

Making the Grade

The George Washington University
School of Public Health and Health Services
1350 Connecticut Avenue, NW #505
Washington, DC 20036
Phone: 202-466-3396
Fax: 202-466-3467
E-mail: mtg@gwu.edu
Web site: www.gwu.edu/~mtg

Program Staff

Julia Graham Lear, Director
Jane Koppelman, Deputy Director
Nancy Eichner, Research Associate
Theresa Chapman, Office Manager

Editors: Burness Communications
Design: Len Ringel Graphic Design

Continued from page 2

your school-based health center doesn't truly 'get it,' or if the school isn't 100% enthusiastic, or if parents don't know what you're trying to do, then you have to work hard to help them get it. Otherwise, if your center ever gets in trouble, those people aren't going to say 'Let's help fix the problem,' they're going to say 'Oh, just close it down.'"

Mary Isham, RN, former clinical director of the comprehensive school-based health center at Mission High in San Francisco, believes community support could have saved her center. In 1997, the thriving, five-year-old center (which saw an average of 40 students per day) fell victim to a larger political battle over community resources. Opponents included the superintendent of schools and the school principal, who opposed funding the center in favor of opening a community clinic when two already existed in the neighborhood. "I think the broader community could've saved the center, if we had been better organized," Isham said. "We almost did it, but we were too late. We had always intended to form a community advisory panel, but it never got done."

Today, those who opposed the school-based health center—which had been open year-round to all adolescents in the community—are gone, and the $180,000 state-of-the-art facility that was built just before the center closed stands empty. But a coalition of students around the city are hoping to rectify that situation by lobbying the city for funds to open school-based health centers in several of the city's high schools (see "Students Rally Around SBHCs" in this issue).

Beyond the broader community support, Isham wishes she had had more political support from the sponsoring organization: San Francisco State University. "We had a small, tight crew in the School of Nursing," she said, "but we didn't develop a strong support system at the university. Even in the nursing department, there wasn't total buy-in. We should've sought more ownership of the center by the entire university, established a broader base."

BEST COPY AVAILABLE

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

SBHCs and Alternative Schools: A Good Match

School-based health centers in alternative schools face unique challenges in serving students who most often have had a rocky relationship with the educational system.

While the reasons for alternative school enrollment are highly variable, students all share a common issue: they cannot function well in a mainstream environment. Often alternative school students have been expelled from a traditional school, dropped out to have a baby, or are referred by the courts to clean up a drug, alcohol, or other problem that led to a legal offense. In a sense, the task of identifying the students in need of school-based health center services is not necessary in an alternative school. By definition, these students stand to benefit most from the presence of a center. To better understand how school-based health centers serve these students, and how their operations may differ from a center based in a mainstream school, ACCESS spoke to professionals involved with centers at four alternative schools around the country.

The U.S. education system is paying increasing attention to meeting the needs of troubled children, as reflected by a 30 percent increase in the number of alternative public schools between 1993 and 1998. That year there were 3,380 public alternative schools around the country serving about one percent of all public school students, according to the U.S. Department of Education. "These kids have not succeeded in a mainstream school and, in many cases, are here as a last resort. Some succeed, others don't," says Beth Spangle, a nurse practitioner at Total Care Center at Independence High School in Winston-Salem, N.C.

© SuperStock, Inc.

Inside This Issue

•1999 National SBHC Census

The entry criteria for alternative schools vary by location. In Minnesota, for instance, students must meet at least one of 10 criteria—such as a mental health diagnosis or a history of adjudication—to qualify for an alternative school, says Sandy Naughton, a health educator at Health Start in St. Paul, MN. Health Start sponsors three centers at alternative schools in the city, in addition to seven others in traditional schools.

"These schools provide students with an education using alternative instructional strategies, while delivering the same curriculum offered in traditional schools and according to state standards," says Bill Lamperes, Ph.D., principal of Centennial High School, Ft. Collins, CO. To help students achieve the goal of getting a diploma, Centennial teaches its kids the phrase *catch the vision*. "At Centennial, the vision is seeing your name on the diploma. We even have a stone at the front door engraved with *catch the vision*. Kids talk about it all of the time. They'll say 'I've got the vision' or, when they feel they are off track, 'I've lost the vision,'" he notes.

Will students ever return to a traditional school? At least at Centennial, the kids have a choice, says Lamperes. "Some want to go back to their home

Continued on next page

PS 029258

Continued from page 1
school to graduate with their peers. We are not the choice of last resort, but rather an interim step to success for these bright, articulate kids," he says.

More Intense Emotional Needs

"Students arrive at the school very needy. The neediness is a result of issues such as sexual abuse, parental issues, and a sense of abandonment," says Lamperes.

As a result, mental health issues are the number one reason that students use the center, says Lori Dugan, Centennial's nurse practitioner. "These are complicated kids. Many are on psychotropic drugs, such as antidepressants or lithium. There often are some serious diagnoses that have already been made before they visit the center," she says.

In 1998, with the aid of a grant, Centennial hired a part-time mental health counselor for the center to see students two mornings each week. With this addition, the center was able to provide 162 mental health visits during the year.

Lamperes says that the reasons for these visits reflect the current student population. "The profile is significantly different than it was several years ago. Today, 93 percent of our kids have had some kind of major loss or emotional disturbance in their lives that involves grief, such as their parents' divorce or the death of friends." Students dealing with the residual effects of sexual abuse are referred to community agencies or private therapists who do pro bono work, says Lamperes. For other issues, such as self-esteem or family problems, the school's mental health therapist runs support groups.

School-based health centers in alternative schools are pressured to find creative solutions to reach those students who are most in need. It is also crucial to maintain an open line of communication between teachers and health professionals. At most of the schools ACCESS interviewed, a health center professional regularly attends teacher meetings to provide updates on students who are referred to the clinic. Such close coordination assures students don't fall through the cracks, but also proves a challenge to the centers, which must protect patient confidentiality.

"We integrate well and often with the school staff to provide a safety net for the kids. Teachers often identify a student with a need. The teachers then come to us and ask for help," says Naughton, who adds that this happens on a daily basis. One technique that Naughton uses with teachers is to get them to help students work on health goals, and to assess issues in their lives that that may affect their wellness. "We try to integrate such work as a part of the students' class assignments." Such integration is important, she believes, since it can signal a student's problem before it erupts into a crisis.

"Students arrive at the school very needy. The neediness is a result of issues such as sexual abuse, parental issues, and a sense of abandonment."

Bill Lamperes

At Centennial High School, peer counselors play an important role with fellow students, says Dugan. "Studies show that peers have the most influence on a teen's behavior," she says. A student accessing the health center will receive one on one counseling with a trained peer counselor before meeting with Dugan. The two review the student's life activities and discuss issues including sexual activity, smoking, drinking and other potentially dangerous behaviors. The student then meets with Dugan and later has a follow-up meeting with the peer counselor. "This gives the student time to meet with someone in their own age group who can later provide positive feedback and congratulate the teen on doing something good, such as not drinking and driving," says Dugan.

Increased Need for Flexibility

Many of the issues that land students in an alternative school surface during health center visits, says Naughton. While a student may come into the center complaining of a sore throat, he could also have a serious drug issue that needs attention, and may not even have a place to stay that night, she notes. "If a student comes to me with a presenting issue, he or she is more likely to have 10 other issues as compared to five with kids in a traditional school," she says.

As a result, the alternative school kids require more time, and the health center staff must plan ahead for this while making appointments, says Naughton. However, getting students to keep appointments can be a problem, since one reason kids may be in an alternative school is that they can't seem to commit to a structured schedule, she adds.

Flexibility in scheduling plays a key role with health professionals working in the centers because alternative schools also often have high drop-out and low attendance rates. At many of the schools where Naughton works, there is only a 50 percent attendance rate, which results in a high failure rate in keeping appointments.

One solution is to strive to make appointments immediately available for the students. "If you don't get to the students on the day that they need help for a problem, your chances of ever reaching them decline more rapidly than in a traditional school, where kids are used to maintaining schedules. We usually overbook appointments because we expect a higher failure rate than we would in a traditional school," says Naughton, acknowledging that they'd have trouble if all of the students appeared for their appointments. More follow-up work is also required of health center staff at alternative schools, she says.

In addition, because alternative school students are usually older and have had trying life experiences, center staff find they get their best responses from these students by treating them like adults. At Centennial High School, for example, the average student age is 16 and the oldest is 20. "Unless you approach them on an adult level and tell them your concerns regarding an activity that is hurtful to them, they'll resent you so fast that they won't walk through the door again," says Bunny Lewis, a nurse practitioner at CrossRoads Alternative School in Medford, Oregon.

This is especially true when dealing with a number of issues such as birth control. Centennial's Dugan works closely with her sexually active patients. "[One girl] told me that she wishes that she'd had someone like me to talk to her about sex at her traditional high school," says Dugan. "She wants to be abstinent, and I talk to her to support her on this.

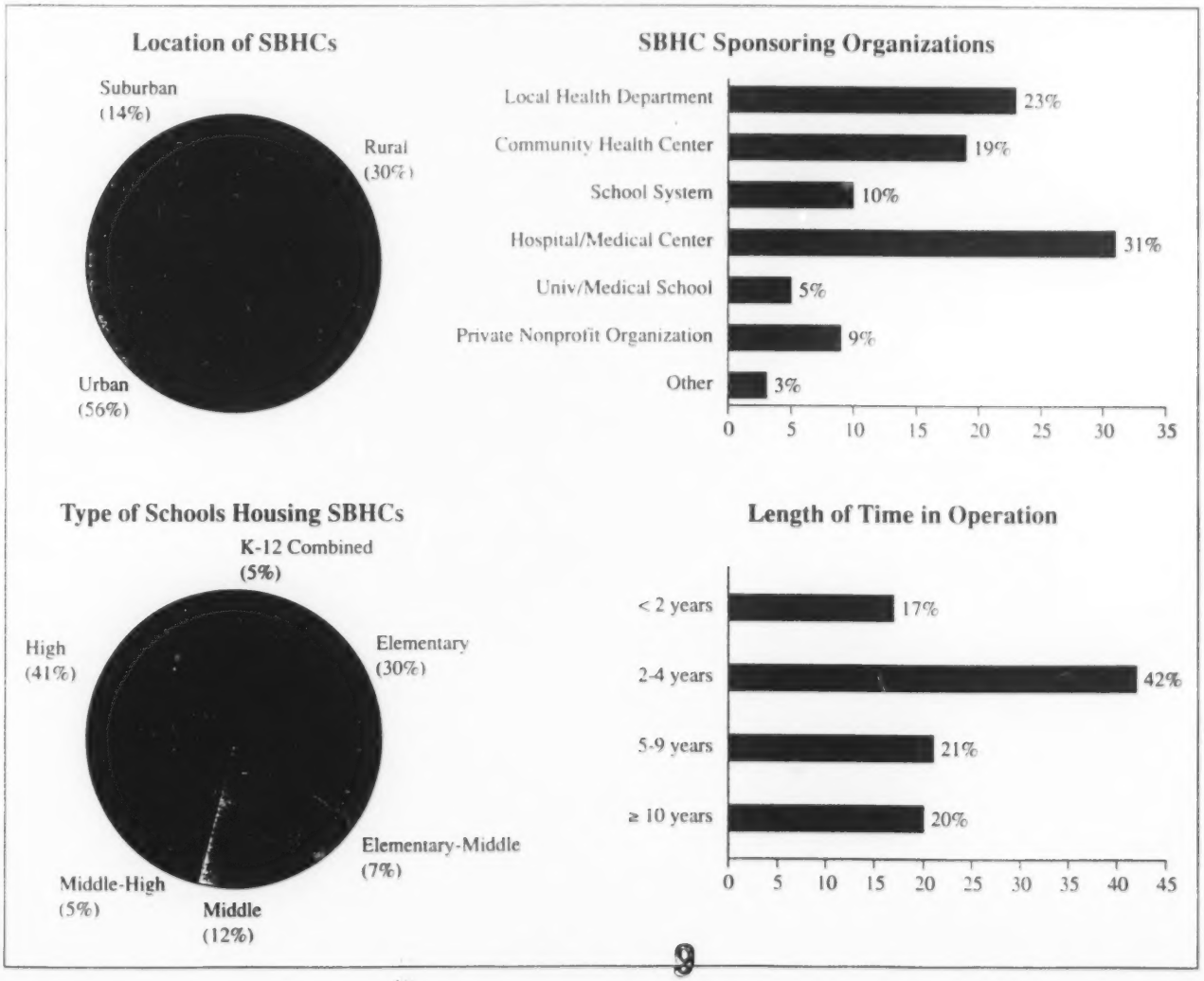
Continued on page 4

National Census Survey Identifies 1,135 SBHCs Nationwide

This summer the National Assembly on School-Based Health Care will release data from the largest national census of individual school-based health centers. Preliminary data from the survey show that there were 1,135 school-based health centers nationwide in 1999. The majority of these centers are located in urban schools, with an increasing number opening in rural settings. In addition, the majority of centers are found in high schools, but centers also are becoming popular for younger children. Hospitals, health departments, and community health centers represent 75% of school-based health center sponsors. And finally, while most centers have been in operation for a total of two to four years, an almost equal number have been operating for five years or more.

The 18-month project, initiated in December 1998, was the National Assembly's inaugural census project. The biennial update of the school-based health center database—conducted by Advocates for Youth and the Support Center for School-Based Health Centers since 1986—was turned over to the National Assembly in the fall of 1998. To obtain the most accurate and up-to-date census data, the National Assembly used a variety of sources to identify school-based health centers, including lists of health centers from the National Assembly membership database, Making the Grade, the federal Healthy Schools/ Healthy Communities program, and the National Association of Community Health Centers. School and adolescent health coordinators in state health and education departments, state school-based health center associations, and individual members of the National Assembly were also contacted to help identify health centers.

The expansive search netted 1,135 school-based health centers as well as 47 school-linked health centers and 33 mobile clinics. Of those, 806 school-based, 28 school-linked, and 12 mobile health centers responded to the census survey. The 70% response rate for school-based health centers will yield the most detailed quantitative assessment of health center and student demographics, staffing, services, and policies of school-based health centers to date. For more information on the survey, contact the National Assembly at 202-638-5872 or visit its website at www.nasbhc.org.



Continued from page 2

The good thing now is that she has a place to come to talk to someone who will listen."

At CrossRoads, family planning is the number one reason that Lewis sees students. "These kids are sexually active, and some are already parents or pregnant at the time I see them," says Lewis. "Abstinence is a joke for them. Since many of the kids were sexually abused before they arrived here, they won't return to a sexually inactive life. Abuse may have been a reason that these kids became confused in the first place. Research supports that if a girl is molested or sexually abused at a young age, she becomes sexually active younger than other girls," she says. Lewis regularly dispenses birth control to students (as with all the centers interviewed for this article, parental permission is required before a student can be seen at a school-based health center).

Most of the time, says Naughton, the students just want someone to smile and talk to them. "You can't take for granted that their parents will ask them how their day went. Sometimes the kids will come in for a Band-Aid, or say that their head hurts, but there is nothing physically wrong with them. They just need some nurturing," she says. The benefit for the health professional is that the need just leaps out at them. "You don't have to dig for what they want. The students are so responsive when someone has a helpful manner," says Naughton.

Lewis seconds that sentiment, saying that the students will just pop into her office to say hi. "You get very close to the kids," she says. The closeness provides a positive influence on many students who tend to stay in touch with her. Recently Lewis received a call from a previous student who had quit smoking, something that the nurse practitioner had tried to encourage her to do for a long time.

One challenge that all centers—both traditional and alternative—face is the need for a stable funding source and to bill insurance for patient care delivered to covered students. But the problem may be more pronounced for centers in alternative schools, where the student population regularly comes from communities with high rates of uninsured families. "Often the students don't even know if they have insurance," says Total Care Center's Spangle. While many alternative schools offer free health services, Lamperes has adopted a policy of charging students a $5 fee per visit out of a desire to make them feel more responsible for the health services they receive.

The drive to make his students both better and healthier citizens was the initial reason that Lamperes worked hard to get the community support to help fund the clinic, which opened in January 1994. Lamperes had noticed that Centennial's students had a high drop-out rate. After scrutinizing the reasons why 26 students left the school, he learned that a personal illness was responsible for 16 of those leaving.

Lamperes made a pitch to establish a center at a public meeting, and solicited community help to get it started. Community members stepped forward. Parents donated their time to paint, hang curtains, and lay carpeting to transform a basement room in the school into a health center. The first year, Centennial operated on $900 worth of private donations. Last year, the school raised $35,000 from grants, anonymous contributions, and a donation from a local foundation.

That spirit of commitment—the willingness to fight to keep school-based health centers operating—was consistent among all four of the alternative schools that ACCESS interviewed. Such centers currently serve as a "stop gap" for the students' health needs, and most are striving to become much more than that.

MTG Launches Monthly E-Journal, *Health and Health Care in Schools*

The face of health and health care in schools is changing. Health promotion and disease prevention programs are attracting greater attention; primary care services are expanding; school nursing services are receiving increased support, and school-based mental health care, especially for teens, has been identified as an effective response to behavior-driven health problems. *Health and Health Care in Schools*, an electronic journal posted on the Making the Grade web site the first week of each month, will cover all of these issues. Focusing especially on the policies, politics, and financing of health programming in schools, the newsletter covers Congressional hearings, federal reports, and court rulings as well as select news from states and local jurisdictions. Go to the Making the Grade home page, located at www.gwu.edu/~mtg, and click on the newsletter listing.

Making the Grade is a national grant program supported by The Robert Wood Johnson Foundation. Under this initiative, the Foundation has funded nine states to establish school-based health centers in local communities and to create state and local policies that support comprehensive care for children and adolescents.

Making the Grade
The George Washington University
School of Public Health and Health Services
1350 Connecticut Avenue, NW #505
Washington, DC 20036
Phone: 202-466-3396
Fax: 202-466-3467
E-mail: mtg@gwu.edu
Web site: www.gwu.edu/~mtg

Program Staff

Julia Graham Lear, Director
Jane Koppelman, Deputy Director
Nancy Eichner, Research Associate
Theresa Chapman, Office Manager

Editors: Burness Communications
Design: Len Ringel Graphic Design

BEST COPY AVAILABLE

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

It's All about Communications: Creating a Compelling Message, Addressing Opposition

Take the SBHC Communications Readiness Quiz

- Do you react to a TV reporter's visit to your SBHC by closing the door, turning off the lights, and ordering patients and staff to lie still on the floor?
- Does a tin cup and a pitiful look seem like the most promising way to raise money for marketing activities?
- Have you decided that you can easily make time in your schedule for marketing your SBHC by simply dressing for work the night before and sleeping in the car?
- Would you rather weather a surprise JCAHO accreditation visit than testify before your state legislature?

If you answered "yes" to at least one of the above statements, it's time to think more strategically about your communications activities. The accompanying article should be of some help.

The growth and survival of school-based health centers hinge on successful communications—both offensive and defensive. To seek more public support and dollars, center advocates must be able to deliver a clear and compelling case for their value—one that resonates with the public. They must also be aware that growth fosters greater visibility, which in turn may invite opposition.

Recently, opposition has emerged in several important places. In 1999, radio talk show host Dr. Laura led a successful campaign in California to defeat a bill that would have set state standards for school-based health centers. This summer, Senator Jesse Helms made a failed but energetic attempt to bar federally funded school-based health centers from dispensing emergency contraception. And in North Carolina, leading—and often liberal—newspapers have sided with opponents of school-based health centers, arguing that they burden already fragile public school systems.

This past spring, *Making the Grade* assembled a group of health care, education, and communications experts to ask their advice on how best to communicate the value of school-based health centers to the public as well as respond to controversy. The following insights are from the experts' discussion.

BUILDING A POSITIVE MESSAGE

Prevention is always the best strategy. Before someone suggests that your center is providing services without parents' knowledge, take time to let your community know exactly how you operate, what services you provide, how parents and other community members are involved in the program, and why they've decided you are needed in the school. Should controversy arise, use the attention it creates as an opportunity to make the case for the value of centers. Here are suggestions for developing your message:

Make sure your message responds to the major concerns of the public. Public opinion polls reveal that the following are of concern to the public:

- A March 2000 Gallup Poll found that education was listed as the most important problem facing the country, and the worst problem facing respondents' communities (Newport).
- The same poll found that taking care of children and family was the second biggest challenge Americans reported facing in their daily lives.
- Drug use, crime, family breakdown, and low-quality education were the four greatest problems confronting American children today, according to a 1998 analysis of 70 public opinion polls (Blendon et al.).

Tell your audience how school-based health centers respond to these worries. These statements are supported by the research studies noted.

Concerning education:

- School attendance. Health center users were absent fewer days from school compared to students who did not use the center (McCord, et al.).

Continued on next page

PS 02258

BEST COPY AVAILABLE

Continued from page 1

• Overcoming school difficulties. Nearly 40 percent of all centers assess and treat students' learning problems (Schlitt, et al.).

• School progression and graduation. Health center registrants were more likely to be promoted or graduated than students who were not registered at the health centers (McCord, et al.).

• Numerous school principals and superintendents report that their centers are essential for well-run schools and students "ready to learn." School boards particularly need to hear that centers help to improve student achievement.

Concerning family responsibilities:

• School-based health centers help parents secure health care for their children—even when the parents can't take off from work.

• Uninsured students with access to a school-based health center have an easier time obtaining physical and dental health services compared to uninsured students with no access to a school-based health center (Kaplan, et al., 1998; Hacker et al., 1997).

• Elementary students with access to a school-based health center were more likely to have had a physician's visit and a dental examination during the school year than students without access to a center (Kaplan et al., 1999).

• Health centers help parents help their their children avoid the risky behaviors—such as drunk driving, fighting, alcohol and drug use—that are the leading causes of injuries and deaths among school-age children.

• Adolescents with access to a school-based health center were ten times more likely to make a visit to a mental health or substance abuse provider (Kaplan et al., 1998).

• Students in schools with school-based health centers were more likely to report seeing social workers and counselors (Santelli et al., 1996).

Concerning drug use, crime, family breakdown and low-quality education:

• Nearly 80 percent of school-based health centers offer crisis intervention services (Schlitt, et al.).

• Nearly 60 percent of school-based health centers provide substance abuse prevention and early intervention programs (Schlitt, et al.).

Link your story to specific needs in your community. Are there barriers to health care access? How many school-age children are uninsured or having difficulty obtaining care? Are there

School-Based Health Cen

1971 and 1973 – First three SBHCs open in Dallas, TX and St. Paul, MN.

1978 – New York legislature approves first state-funded grant program for SBHCs.

Late 1970s – Replication begins. Robert Wood Johnson Foundation funds SBHCs in Commerce City, CO; Posen-Robins, IL; Houston, TX; Chicago, IL; Kansas City, MO; New York City, NY and New Haven, CT.

The Pill Goes to School

1984 – SBHCs draw public controversy.

1985 – First national tally taken of SBHCs by Center for Population Options – 33 counted.

1986 – Second national tally finds 74.

1986 – RWJF launches the School-Based Adolescent Health Care Program – 24 new centers funded.

1986 – Arkansas, Connecticut, Delaware, Michigan, and Oregon fund SBHCs.

1989 – Health professional groups endorse SBHCs.

1990 – Federal government says SBHCs can help achieve nation's Year 2000 health goals.

1991 – Bush Administration recommends SBHCs in elementary schools nationwide.

1993 – Delaware Governor Tom Carper pledges an SBHC in every public high school that wants one.

1993 – $3 billion for school health, including SBHCs, included in Clinton Administration health reform plan.

1993 – National survey finds 300 SBHCs nationwide.

1993 – New York SBHCs start first state association.

To receive a free, full-color poster of this illustrated SBHC timeline, please contact Making the Grade

concerns about school dropout, drug use, and teen pregnancy? To the extent possible, document all claims with data. Your local health department or child advocacy groups are good resources for local data. The Kids Count Data Book, published by the Annie E. Casey Foundation, contains indicators of child well being organized by state (www.aecf.org). The Centers for Disease Control and Prevention have just published 1999 data from the Youth Risk Behavior Survey. National and state figures are available at www.cdc.gov/nccdphp/dash/yrbs.

SHAPING A REBUTTAL

If you find yourself under attack, respond with facts and more facts. Information is the best antidote for opposition.

- If the opposition is targeting the provision of reproductive health services and/or contraception, explain precisely what your school-based health center does and does not do. Describe how and why decisions were made regarding these policies.
- If critics argue that school-based health centers will place extra burdens on an already stressed school system, explain:
  - Who organizes the school-based health center and who is responsible for its budget;
  - How the center is funded, and
  - What the relationship is between the school-based health center and the school.
- Collect data on how many students are not sent home from school because they get care from the health center.
- Remember, there is opportunity in controversy. Use the heat of the public debate to build passion for your perspective.

Seek to understand the philosophical and substantive sources of opposition. Identify the issues and fears within the opposition's argument that resonate with the ordinary citizen. Understand those matters and engage opponents in a respectful way. Assume that everyone involved in the discussion shares a commitment to improving children's well being. Parents may feel worried about the provision of emotional counseling or reproductive health services at school. You can point out that the leading risks to children's health are no longer physical illnesses but risky behaviors.

- Unintentional injuries, homicide, and suicide account for 70 percent of the

Continued on next page

ers into the 21st Century

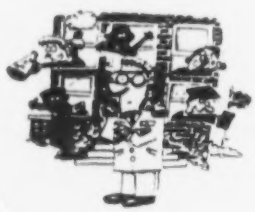
1993 - RWJF funds 9 states to develop SBHC policies and open 44 new centers - Colorado, Connecticut, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island, and Vermont.

MAKING THE GRADE

1994 - "Healthy Schools, Healthy Communities" is born - 1st federal SBHC program.

1994 - National health reform plan dies.

1995 - National Assembly for School-Based Health Care convenes.



1996 - Kellogg Foundation funds 9 SBHCs in Detroit; throws support to NASBHC.

1996 - 31 states plus D.C. make grants to SBHCs.

Mid to Late 1990s - Arizona uses tobacco tax money to raise number of SBHCs from 33 to 85.

1996 - C. Everett Koop, former Surgeon General, "In my professional lifetime the health of every group of American society has improved except for teenagers. Isn't school the best place for a primary health care facility?"

1996 - SBHCs total 900.

1996-2000 - More state associations form in Arizona, California, Colorado, Connecticut, Florida, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, North Carolina, Oregon, Pennsylvania, Rhode Island, Texas, and West Virginia.

1998 - SBHCs in 22 states have contracts with managed care plans.

1998 - SBHCs have spread to elementary schools. One-third of all centers serve younger children.

2000 - Louisiana and Massachusetts fund SBHCs with tobacco settlement dollars.

2000 - SBHCs are open in 28 of 29 public high schools in Delaware.

2000 - SBHCs in 45 states number over 1,200.

2050 - Humans colonize space.

2052 - Uranus funds first school-based health pod.

Illustration: -STAMOSKI-

BEST COPY AVAILABLE

Continued from page 3

deaths to school-age children and youth. The role of alcohol and drug use in these deaths is substantial.

• The rates of teen sexual activity have increased over the past two decades and sexually transmitted diseases and AIDS have given this activity health damaging, if not deadly, consequences.

(Note: These and other data from the Centers for Disease Control and Prevention are available in *Health, United States 2000: Adolescent Health Chartbook* at www.cdc.gov/nchs/whatsnew.htm.)

While the opposition may rekindle feelings for the way things used to be, most parents recognize that the stresses and responsibilities of raising children today differ substantially from those of their parents' generation. Remind them! School-based health centers are one of many practical services offered in schools to help families thrive in a challenging world.

DELIVERING THE MESSAGE: THREE QUICK RULES

1. Use the free press. Your local newspapers and television stations are the best venues for delivering your message. Having the media present your information enhances its legitimacy and is the best strategy for reaching the widest audience. Use standard "theme" stories (i.e. back-to-school, surviving flu season, helping kids stay healthy, end-of-school activities) as hooks to attract local print and television reporters;

2. Use the community papers and the free neighborhood weeklies and newsletters to spread your message. These community-focused publications are almost always interested in school news and local perspectives. They are effective vehicles for building a strong consumer base for your program.

3. Respond quickly if your program is attacked. Use the press contacts you made while building a positive message to present your case to as many audiences as possible. Elected officials will tell you that it is critical to answer charges quickly, calmly, and accurately.

FINDING POLITICAL ALLIES TO BUILD YOUR SUPPORT

Most communities do not contain large numbers of school-based health centers. To continue to grow, health centers will need to build the networks essential to securing public support and political will. Health center staff, as harried as they are, must find time to explain to other children's advocates why their common agenda can be met through the establishment of more school-based health centers.

• Likely allies include child advocacy groups, PTAs, school nurses,other child health professionals, school boards, and school personnel.

• Less obvious allies include business leaders committed to strengthening schools; civil rights groups that may be concerned about racial disparities in access to health care; or youth groups and sports leagues that have had difficulty securing physical examinations and care for their young members.

• Remember that allies will expect your support for their issues. The partnership must be mutual to survive.

• Friends and allies are critical to promote the centers and defend against attack.

• Take heart. According to William Dyson, chair of the Connecticut Assembly's House Appropriations Committee: "There's nothing that has a greater effect on influencing what takes place (in the state legislature) than the groundswell of a group that appears to be together and unanimous in what they want to do."

The editors thank our communications experts: Mike Usdan, President, Institute for Educational Leadership, Inc.; Cory Richards, Vice President, Alan Guttmacher Institute; Jeff Nesbit, President, Shiloh Communications; Roberta Cooper, Deputy Director, New York Regional Office, People for the American Way; Nancy Gelbard, Chief of School Health Connections, California Department of Health Services; Kathleen Finnigan, Chief Consultant for California Assembly, Aging and Long-Term Care Committee.

REFERENCES

Blendon RJ, Young JT, McCormick MC, Kropf M, Blair J (1998). Americans' views on children's health. JAMA 280, 2122-2127.

Hacker KA, Weintraub TA, Fried LE, Ashba J (1997). Role of school-based health centers in referral completion. J of Adol Health, 21, 328-334.

Kaplan DW, Brindis CD, Phibbs S., Melinkovich P, Naylor K, Ahlstrand K (1999). A comparison study of an elementary school-based health center: Effects on health care access and use. Arch Pediatr Adolesc Med, 153, 235-243.

Kaplan DW, Calonge BN, Guernsey BP, Hanrahan MB (1998). Managed care and school-based health centers: Use of health services. Arch Pediatr Adolesc Med, 152, 25-33.

McCord M.T., Klein JD., Foy J.M, Fothergill K (1993). School-based clinic use and school performance. J of Adol Health, 14, 91-98.

Newport F (2000). Economy, education, health, crime and morality most on Americans minds this election year. Poll releases, June 22, 2000. The Gallup Organization: Princeton, NJ; accessed July 12, 2000 at www.gallup.com/poll/releases/pr000622b.asp

Santelli J., Kouzis A., Newcomer S (1996). School-based health centers and adolescent use of primary care and hospital care. J of Adol Health, 19(4), 267-275.

Schlitt J, et al. (2000). Creating access to care: school-based health center census 1998-99. National Assembly on School-Based Health Care: Washington, DC.

Making the Grade is a national grant program supported by The Robert Wood Johnson Foundation. Under this initiative, the Foundation has funded nine states to establish school-based health centers in local communities and to create state and local policies that support comprehensive care for children and adolescents.

■ ■ ■

Making the Grade

The George Washington University
School of Public Health and Health Services
1350 Connecticut Avenue, NW #505
Washington, DC 20036
Phone: 202-466-3396
Fax: 202-466-3467
E-mail: mtg@gwu.edu
Web site: www.gwu.edu/~mtg

Program Staff

Julia Graham Lear, Director
Jane Koppelman, Deputy Director
Nancy Eichner, Research Associate
Theresa Chapman, Office Manager

Editors: Burness Communications
Design: Len Ringel Graphic Design

BEST COPY AVAILABLE

Final Issue —WINTER 2001

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

Moving Forward: Making the Grade Becomes the Center for Health & Health Care in Schools

The 1990s brought major gains for school-based health centers: attention from a Republican president, new funds from state legislatures and the federal government, and the creation of a national school-based health center membership organization. The decade also brought some difficult challenges for the centers: the need to sustain a growing number of centers while adjusting to the impact of managed care. It was also the decade of Making the Grade, the national grant program created by the Robert Wood Johnson Foundation (RWJF) in 1993 to help establish new school-based health centers through state and local partnerships.

Today, after a successful seven-year run as a funder of new school-based health centers, a broker of new relationships, and a facilitator of supportive public and private policies, Making the Grade is becoming the Center for Health and Health Care in Schools. The Center's purpose is to serve as a national resource center on health programs of all sorts that are located in schools.

"The terrain is very different now than when Making the Grade was launched," said Julia Graham Lear, director of Making the Grade and the new Center. "There was no national association and only one state (New York) association of school-based health centers. There were few researchers interested in the topic and relatively few organized advocates. All are now present and doing some sophisticated advocacy work around matters that are important to the future of school-based health centers.

"I'm very optimistic that their work will continue while the Center takes up issues that the field may not have gotten to yet," she said. "For example, an initial priority will be examining effective ways of delivering dental services through school-based health centers and refining our understanding of effective and sustainable models for prevention and mental health programs in school-based health centers."

The Center for Health and Health Care in Schools is based at The George Washington University and is co-sponsored by its School of Public Health and Health Services and Graduate School of Education and Human Development. Contact information for the Center is the same as it was for Making the Grade: 1350 Connecticut Avenue, NW #505, Washington, DC 20036. Phone: 202-466-3396. Fax: 202-466-3467. The Center's Web site address is: www.healthinschools.org.

Making the Grade in Perspective

The well-documented history of school-based health centers tells us that the first center opened in the early 1970s, and throughout that decade, growth was slow, with school-based health centers opening in a handful of communities around the country. In 1978, New York established the first state grant program to support the creation of new school-based health centers. By 1985, there were less than 50 school-based health centers in the nation, but the concept had found a foothold. In 1986, RWJF funded the School-Based Adolescent Health Care Program, a national grant program that resulted in the creation of 24 centers. By 1990, there were 150 centers serving approximately 137,000 students nationwide.

In the early years, school-based health centers were the focus of controversy in a number of communities. Issues of concern included the provision of reproductive health care services to teenagers and centers usurping parental authority by providing such care. During the 1990s, however, debates became less frequent and the centers continued to expand. In the '90s, the key issue was not political but financial: Where would money come from to open new centers in an era of managed care?

"When the School-Based Adolescent Health Care Program was nearing its conclusion, we realized that school-based health centers were almost, but not quite, to the point where they might really take off," said Paul Jellinek, RWJF vice president. "And in fact, they seemed to be nearing a make or break point and we thought it would be a shame to walk away at such a critical time."

Continued on page 4

Inside This Issue

- Parting Words from the MTG Grantees
- Improving Quality of Care in Centers

PS 029258

Parting Words from MTG Grantees

In his article, "Back to School: A Health Care Strategy for Youth," which appeared in the January/February 2001 issue of *Health Affairs*, Making the Grade (MTG) evaluator James Morone referred to the MTG state grant directors as "bureaucratic activists." He noted that in every state he studied, the "innovating spark" that created school-based health centers "flew not up from the grassroots but down from state government."

Since these "bureaucratic activists" carried out the vision of MTG in their states, ACCESS is now giving them the last word. We asked each of the nine grant directors to describe their state's experiences by answering these two questions: 1) How would you sum up what MTG has meant for school-based health centers in your state? 2) Now that MTG is ending, what does the future hold for centers in your state? Obviously, it is difficult to sum up six years of work in a few hundred words, but here, in their own words, is a sense of their accomplishments.

COLORADO
Bruce Guernsey
MTG provided a base within state government to forge the broad partnerships needed at all levels for changing the way health care and mental health services are delivered to children and adolescents. The grant dollars and the status of the award afforded a platform for leadership and innovation in Colorado. Almost one-third of the centers in our state were created through MTG.

In the post-MTG era, we have established the non-profit Colorado Association for School-Based Health Care (CASBHC). Through CASBHC, centers have set up systems for measuring the quality of their services; enhanced visibility of center programs within their communities; become adept at tapping new funds as they become available; and improved their image through a public education campaign targeted at policy makers. The State Office continues to function within the Department of Public Health and Environment, providing leadership within state government, support for CASBHC, and Maternal and Child Health funding.

CONNECTICUT
Donna Christensen
We have seen impressive growth in school-based health centers during Connecticut's participation in MTG. When we received our grant, the Department of Public Health (DPH) funded 28 centers. Connecticut now has 57 centers that meet the DPH's guidelines, and three more are being developed. This growth has taken place despite a state spending cap and regular calls for state agencies to trim budgets. And because MTG required collaboration among many entities, we were able to form close linkages with other state agencies with the shared goal of supporting the centers. Through these partnerships, Connecticut has become a leader on issues related to managed care reimbursement and is one of the few states to make all centers part of the managed care network. In addition, the Connecticut Association for School Based Health Centers (another CASBHC) was formed with support from MTG.

Connecticut is well positioned to assure the ongoing role of centers in providing access to quality services to our youth. One of the most important legacies of MTG has been the strengthening of a shared statewide commitment to our centers. The CASBHC will continue to advocate for children's health, in general, and for the enhancement of centers, in particular.

Photo by Elinor S. Cohen

LOUISIANA
Sylvia Sterne
When MTG began in Louisiana, we had nine centers operating and 10 others planned. There are now more than 40 centers, with more being planned. MTG not only funded five centers, but also, by funding both urban and rural sites, demonstrated that centers could be successful in both settings. MTG also enabled us to hire a public relations consultant, who helped our sites become effective advocates for school-based health centers. And MTG and the support of the Robert Wood Johnson Foundation validated school-based health centers, which gave weight to our arguments during state funding debates.

In the past, we have faced serious threats during the annual appropriations process. Most notable have been the Christian right's efforts to destroy the program, which we have been able to neutralize by forming relationships with Catholic hospital executives and proving that our centers have done nothing illegal nor inappropriate. Despite the threats, funding for centers has continued to increase. The state legislature has increased its support annually, and the state has pledged it tobacco settlement funds in support of centers. In addition, the Governor's Children's Cabinet adopted expansion of the centers as its top priority.

MARYLAND
Donna Behrens
Maryland's MTG grant allowed for a single unit to be developed in the Governor's Office that could focus solely on school-based health centers and bring the expertise of the state's health and education departments into a collaborative effort. When MTG began, school-based/school-linked health centers in Maryland numbered in the mid-20s and were located in five counties and Baltimore. This year, Maryland is anticipating 61 school-based health centers (all school-linked programs have subsequently closed) in 10 of its 24 jurisdictions. This past legislative session, the School-Based Health Center Initiative was funded in full to continue its efforts, with an additional $2 million added to expand school-based health centers throughout the state.

I am very optimistic that school-based health centers are firmly entrenched in Maryland and that they will continue to grow in number. I think there also will be an expansion of existing services and an increase in the types of services offered. But we do have some challenges before us. The centers must continue working within the managed care environment, instituting quality assurance measures, improving the level of third-party reimbursement, and documenting the results and outcomes of the care delivered.

NEW YORK
Taimi Carnahan
As a MTG grantee, New York received a number of benefits: 1) valuable information on current and emerging issues provided through the MTG national program office; 2) site visits by MTG and other experts that have provided technical assistance in addressing school-based health center issues; 3) a communication link with other MTG grantees around the

Continued on page 3

Improving Quality of Care in School-Based Health Centers

Despite all the talk about school-based health centers—how to structure, staff, finance, and sustain them—what matters most is whether or not they're delivering high-quality care that is accessible, appropriate, and effective. While other issues are important, they become moot if delivering high-quality care is not among a center's highest priorities.

But how is a school-based health center to know if it is delivering high-quality care? Quality is a difficult and complex thing to measure. And once quality measures are taken, and assuming changes are made as a result, how is a center to know if the adjustments improved care? If the effort is to prove meaningful, measuring quality is something that must be done regularly and consistently, with an eye toward identifying areas for improvement—a process known as continuous quality improvement, or CQI.

"CQI is not one of the top 100 things a school-based health center should do, it's one of the top five things it absolutely must do," said Julia Lear, PhD, director of Making the Grade and the Center for Health and Health Care in Schools. "Too frequently, centers have operated on the assumption that 'we're good people doing good things and just the fact that we're here means we're improving kids' lives.' That's not enough. If school-based-health centers are to operate as part of the mainstream health care system, including contracting with managed care organizations, they need to document what they're achieving, particularly around clinical outcomes."

A New Tool Takes Shape

To help school-based health centers with the difficult task of assessing and improving quality, a CQI tool has been developed by three national experts with support from Making the Grade (which has since become the Center for Health and Health Care in Schools, CHHCS). The experts include Linda Juszczak, DNS, PNP, CPNP, nurse practitioner in adolescent medicine at North Shore University Hospital; Doris Pastore, MD, medical director of the School-Based Health Center Program at Mount Sinai Adolescent Center; and Christopher Reif, MD, director of Community Medicine for Ramsey Family Physicians. All three direct or have directed a school-based health center program, and each tested the tool in their own centers. They also solicited feedback from other school-based health centers at several points during the early development process.

"The tool has gone through extensive revisions since our first draft," said developer Doris Pastore. "We got a lot of important feedback from the field that helped us refine this tool to meet the needs of school-based health centers."

Making the Grade originally was prompted to sponsor the development of the CQI tool by the findings of several clinical site visits to school-based health centers. According to Christopher Reif, who conducted some of the site visits, "We noticed that every center had some way of measuring what they did, and they usually called their measure a 'quality'

Continued on back page of insert

Method of Evaluation of Clinical Services in School-Based Health Centers

Introduction to CQI Tool

School-based health centers (SBHCs) are designed to detect and address the significant health problems and health risks of each age group among school-age children, i.e. elementary, middle or junior high, and senior high students. A comprehensive annual risk assessment (and biannual physical exam) is essential to detecting and addressing all important health concerns of the students at each level of school. Within each age group there are certain conditions that stand out because they represent typical health risks for that age and because they may serve as a measure of good health care delivered. This chart presents seven "Sentinel Conditions" for each school age group.

It is important to highlight several points about the sentinel conditions. First the sentinel conditions are clinically based. That is, they represent those conditions of health commonly encountered and treatable in a SBHC setting. Next, a limited number of conditions were chosen for several reasons. It allows each health center to focus on a meaningful evaluation. It facilitates local and national comparisons between sites and it allows for additions and changes to the list of conditions in future years as success is achieved with the initial measures.

Thus the list of sentinel conditions is purposefully not comprehensive. Rather, they are intended to be the "core measure" of quality in school-based health centers. It is understood that SBHCs will be subject to quality measures from other sources and agencies and depending on the services provided (e.g. dental, prenatal, well child care). For these added services, additional quality measures will necessarily be developed and applied.

BEST COPY AVAILABLE

SENTINEL CONDITIONS	REFERENCES[1]	RESOURCES	MARKERS	MEASUREMENT[2]
• ***Annual Risk Assessment***[3] • ***Biannual Physical Exam***	• Bright Futures • HEDIS • AAP • USPHSTF • PPIP	• Physical space is adequate for confidential screening/exams • Medical record forms available • Permission from parent or other responsible adult	• % of charts with record of annual risk assessment • % of charts with record of biannual physical exam	1 = 0-25% of charts with both markers documented 2 = 26-50% 3 = 51-75% 4 = 76-95% 5 > 95%
Asthma, Chronic	• AAAI • NHLBI • AAP	• Asthma plan • Peak flow meter • Primary care physician • Parental permission	• % of students with asthma plan • % of visits in "green zone" or • (*) % of students with no symptoms of cough or wheeze, improved lung function, reduction in number of severe attacks, minimized sleep disturbance, and improved attendance in school, and reduction in number of hospitalizations	1 = 0-40% of charts have asthma plan 2 = 41-60% 3 > 60% 4 = Above plus 50-75% of visits show the student in green zone or (*) 5 = Above plus >75% of visits show student in green zone or (*)
Incomplete Immunizations	• AAP Red Book • State Registries • Local Health Departments	• List of required immunizations by state • Educational materials for parents • Parent permission • Chart form for immunization records • Policy for tracking students with incomplete immunizations • Policy regarding communication and collaboration with school administration, school nurse, guidance counselor, social worker, school psychologist, and faculty	• % of students behind in immunizations that are brought up to date	1 = 0-25% of records show that students behind in immunizations are brought up to date 2 = 26-50% 3 = 51-75% 4 = 76-95% 5 > 95%
High Risk for Unintentional Injury	• Bright Futures • AAP • CDC • Safe Students • Children's Safety Network • PPIP	• List of significant injuries to be prevented • Screening form in history • Primary prevention aides for students and parents • List of community resources • Planned school-wide health and safety promotional events	• % of students at risk for unintentional injury with injury prevention materials sent home to family or documentation that student received instruction regarding risk reduction	1 = 0-25% show evidence of prevention materials sent home 2 = 26-50% 3 = 51-75% 4 = 76-95% 5 > 95%

BEST COPY AVAILABLE

Poor School Performance	• Bright Futures Mental Health • DSM-PC	• Name of school academic counselor for each student • Information regarding absences and discipline • Policy regarding communication and collaboration with school administration, school nurse, guidance counselor, social worker, school psychologist, and faculty • Identified list of performance indicators from school: dropping grades, failing two or more classes, suspension from school, skipping school, trouble getting homework done, lack of interest	• % of students with school failure are assessed for medical and mental health problems and plan is in place • % of students with school failure are referred and followed up for education plan to address problem	1 = 0-50% of charts show record of medical and mental evaluation and referral 2 = 51-95% 3 > 95% 4 = Above plus 50-75% have evidence of follow-up plan, linkage and referral for academic services 5 = Above plus >75%
Mental Health[4] ***Students Being Treated for ADHD***	• AAP • AHCPR • DSM-PC • NIMH	• Knowledge of treatment plan from provider • Knowledge of student performance • School IEP • Medication log • Policy regarding communication and collaboration with school administration, school nurse, guidance counselor, social worker, school psychologist, and faculty	• % of charts with documentation of treatment plan • % of charts with documentation of, compliance with, and effectiveness of the treatment plan	1 = 0-20% of charts with plan 2 = 21-50% of charts with plan 3 > 50% of charts with plan 4 = Above plus 50% of charts with compliance check and effectiveness evaluation 5 = Above plus >50% of charts with compliance check and effectiveness evaluation
Child Abuse	• State regulations • School policy • AAP • Guidelines for professional disciplines	• Policy regarding reporting suspected child abuse • Policy regarding communication and collaboration with school administration, school nurse, guidance counselor, social worker, school psychologist, and faculty • Legal reporting requirements • Local resources • Child Abuse Quarterly Medical Update • Institute for Professional Education	• % of students at risk are reported to appropriate agencies • % of students receiving ongoing case management (for those who remain at school)	1 = 0-50% of students identified are connected to appropriate agency 2 = 51-95% 3 > 95% of students identified are connected to appropriate agency 4 = Above plus 50-75% of students remaining in school are receiving ongoing case management 5 = Above plus >75% of students remaining

[1]Links to each of these references is available on the Center's Web site (www.healthinschools.org/quality.asp).
[2]Scale of markers: 1 and 2 = below threshold; 3 = at threshold; 4 and 5 = above threshold.
[3]Annual Risk Assessment and results of Biannual Physical Exam should be in the chart by the third visit.
[4]Each program should choose one of the two Mental Health conditions for evaluation.

SENTINEL CONDITIONS	REFERENCES[1]	RESOURCES	MARKERS	MEASUREMENT[2]
• ***Annual Risk Assessment***[3] • ***Biannual Physical Exam***	• Bright Futures • HEDIS • AAP • USPHSTF • PPIP • GAPS	• Physical space is adequate for confidential screening/exams • Medical record forms available • Parental permission documented • Parent or other responsible adult present • Policy on adolescent confidentiality and receipt of health services	• % of charts with record of annual risk assessment • % of charts with record of biannual physical examination	1 = 0-25% of charts with both markers documented 2 = 26-50% 3 = 51-75% 4 = 76-95% 5 > 95%
Tobacco Use	• USPHS Clinical Practice Guidelines for Treating Tobacco Use & Dependence in JAMA • ALA • AMA • AAP • ETR • PPIP	• Age appropriate screen • Policy on adolescent confidentiality and receipt of health services • Treatment plan or referral for treatment • Names of school substance abuse resources and community resources • Information about prevention for parents • Planned school-wide health promotion events	• % receiving intervention (treatment or referral) • % adherent to intervention plan • % cessation	1 = 0-50% receive intervention 2 = 51-95% receive intervention 3 > 95 % receive intervention 4 = Above plus 50% compliant with plan 5 = Above plus 20% report smoking cessation
Risk of Pregnancy	• GAPS • Bright Futures • AMA • Planned Parenthood • SEICUS • PPIP • ETR	• Staff education, comfort, confidence re: adolescent pregnancy prevention • Policy on adolescent confidentiality • Patient health education materials • Family Planning services on site or referral for • Methods available to treat • Pregnancy prevention program in place	• % of sexually active students with prevention plan • % of sexually active students with documented risk reduction	1 = 0-50% of at risk students have documented prevention plan 2 = 51-95% 3 > 95% 4 = Above plus 50% of charts have documented a risk reduction 5 = Above plus >50% of charts have documented a risk reduction
Poor School Performance	• Bright Futures Mental Health • DSM-PC	• Name of school academic counselor for each student • Information regarding absences and discipline • Policy regarding communication and collaboration with school administration, school nurse, guidance counselor, social worker, school psychologist, and faculty	• % of students with school failure are assessed for medical and mental health problems and plan is in place • % of students with school failure are referred and followed up for education plan to address problem	1 = 0-50% of charts show record of medical and mental evaluation and referral 2 = 51-95% 3 > 95% 4 = Above plus 50-75% have evidence of follow-up plan, linkage and referral for academic services

		• Identified list of performance indicators from school: dropping grades, failing two or more classes, suspension from school, skipping school, trouble getting homework done, lack of interest		5 = Above plus >75%
Parent-Child Conflict	• Bright Futures • GAPS • DSM-PC	• Policy regarding confidentiality • List of community resources and agencies for families • On-site support for mental health • Medical and mental health evaluation for contributing factors (e.g., chemical use, family chemical use, physical abuse, depression, etc.) • "Family Conflict Scale" • Screen for co-morbidities	• % of students with history of parent child conflict are evaluated and assessed for contributing factors and co-morbidities • % of students with history of parent-child conflict have a plan to address problem • % of students showing reduction of conflict	1 = 0-50% evaluated and assessed 2 = 51-95% 3 > 95% 4 = Above plus 75% have a plan 5 = Above plus 35% show reduction in conflict
Mental Health[4] ***Students Being Treated for ADHD***	• AAP • AHCPR • DSM-PC • NIMH	• Knowledge of treatment plan from provider • Knowledge of student performance • School IEP • Medication log • Policy regarding communication and collaboration with school administration, school nurse, guidance counselor, social worker, school psychologist, and faculty	• % of charts with documentation of treatment plan • % of charts with documentation of compliance with and effectiveness of the treatment plan	1 = 0-20% of charts with plan 2 = 21-50% of charts with plan 3 > 50% of charts with plan 4 = Above plus 50% of charts with compliance check and effectiveness evaluation 5 = Above plus >50% of charts with compliance check and effectiveness evaluation
At Risk for Depression	• GAPS • DSM-PC • AHCPR • SAMHSA	• Teen confidentiality • Pediatric Symptom Checklist • Access to resources for full mental health evaluation • Psychiatric referral	• % with completed evaluation, referral and plan • % showing improvement	1 = 0-50% with completed evaluation, referral, and plan 2 = 51-95% 3 > 95% 4 = Above plus 25%-50% show improvement 5 = Above plus >50% show improvement

[1]Links to each of these references is available on the Center's Web site (www.healthinschools.org/quality.asp).
[2]Scale of markers: 1 and 2 = below threshold; 3 = at threshold; 4 and 5 = above threshold.
[3]Annual Risk Assessment and results of Biannual Physical Exam should be in the chart by the third visit.
[4]Each program should choose one of the two Mental Health conditions for evaluation.

SENTINEL CONDITIONS	REFERENCES[1]	RESOURCES	MARKERS	MEASUREMENT[2]
• ***Annual Risk Assessment***[3] • ***Biannual Physical Exam***	• Bright Futures • HEDIS • AAP • USPHSTF • PPIP • GAPS • HEADSS	• Physical space is adequate for confidential screening/exams • Medical record forms available • Parental permission documented • Policy on adolescent confidentiality and receipt of health services	• % of charts with record of annual risk assessment • % of charts with record of biannual physical examination	1 = 0-25% of charts with both markers documented 2 = 26-50% 3 = 51-75% 4 = 76-95% 5 > 95%
Alcohol Use	• GAPS • NIDA • SAMHSA • AAP • ETR • PPIP	• Policy regarding communication and collaboration with school administration, school nurse, guidance counselor, social worker, school psychologist, and faculty • Policy on adolescent confidentiality and receipt of health services • Names of school and community substance abuse programs • Referral relationship with substance abuse programs • Information about prevention for parents • Screening tool (i.e. CAGE, AUDIT) • Screen for co-morbidities	• % of students using alcohol evaluated for co-morbidities and abuse • % of students abusing or at high risk for abuse with intervention, plan, and/or referral • % with reduced risk or reduced abuse	1 = 0-50% evaluated for co morbidities and abuse 2 = 51-95% 3 > 95% 4 = Above plus 50% of those evaluated with evidence of intervention, plan or referral 5 = Above plus 10% report drinking cessation
Risk of Personal Violence	• CDC • Hamilton Fish Institute • SAMHSA • PPIP • GAPS	• List of categories of violence to be prevented e.g., rape, abuse, weapons, fighting, gangs, suspension, arrest • Screen for co-morbidities • Primary prevention aides for students and parents • List of community resources • Planned school-wide health and personal safety promotional events	• % of those at risk with evaluation and plan • % with reduced risk	1 = 0-50% with intervention, plan, and referral 2 = 51-95% 3 > 95% 4 = Above plus 25-50% reduced risk 5 = Above plus > 50% reduced risk
Risk of STI	• GAPS • CDC Guidelines • IOM • PPIP	• Risk assessment for STI • Protocols for diagnoses and treatment of STIs • Referral resources for further evaluation and treatment	• % with appropriate assessment and treatment • % with documented risk reduction	1 = 0-50% with appropriate assessment and treatment 2 = 51-95% 3 > 95%

		• On-site resources for diagnosis and prescription of STI • List of contributing factors to STI, e.g., sexual contact • Stages of Change training		4 = Above plus 25%-50% report reduced risk at next visit 5 = Above plus >50% report reduced risk at next visit
Poor School Performance	• Bright Futures Mental Health • DSM-PC	• Name of school academic counselor for each student • Information regarding absences and discipline • Policy regarding communication and collaboration with school administration, school nurse, guidance counselor, social worker, school psychologist, and faculty • Identified list of performance indicators from school: dropping grades, failing two or more classes, suspension from school, skipping school, trouble getting homework done, lack of interest	• % of students with school failure are assessed for medical and mental health problems and plan is in place • % of students with school failure are referred and followed up for education plan to address problem	1 = 0-50% of charts show record of medical and mental evaluation and referral 2 = 51-95% 3 > 95% 4 = Above plus 50-75% have evidence of follow-up plan, linkage and referral for academic services 5 = Above plus >75%
Mental Health[4] ***Students Being Treated for ADHD***	• AAP • AHCPR • DSM-PC • NIMH	• Knowledge of treatment plan from provider • Knowledge of student performance • School IEP • Medication log • Policy regarding communication and collaboration with school administration, school nurse, guidance counselor, social worker, school psychologist, and faculty	• % of charts with documentation of treatment plan • % of charts with documentation of compliance with and effectiveness of the treatment plan	1 = 0-20% of charts with plan 2 = 21-50% of charts with plan 3 > 50% of charts with plan 4 = Above plus 50% of charts with compliance check and effectiveness evaluation 5 = Above plus >50% of charts with compliance check and effectiveness evaluation
At Risk for Depression	• GAPS • DSM-PC • AHCPR • SAMHSA	• Teen confidentiality • Access to resources for full mental health evaluation • Psychiatric referral	• % with completed evaluation, referral and plan • % of showing improvement	1 = 0-50% with completed evaluation, referral and plan 2 = 51-95% 3 > 95% 4 = Above plus 25%-50% show improvement 5 = Above plus> 50% show improvement

[1]Links to each of these references is available on the Center's Web site (www.healthinschools.org/quality.asp).
[2]Scale of markers: 1 and 2 = below threshold; 3 = at threshold; 4 and 5 = above threshold.
[3]Annual Risk Assessment and results of Biannual Physical Exam should be in the chart by the third visit.
[4]Each program should choose one of the two Mental Health conditions for evaluation.

Continued from cover page

measure, but as you can imagine, every site had something different going on. None of their measures were being graded against a meaningful standard, and certainly not against a national standard. Their ideas of quality measures were really just checklists of things they did for each patient—checklists that were impossible to interpret in any meaningful way."

It was decided that a standardized CQI process was needed—one that would enable school-based health centers to grade themselves against national practice standards and guidelines published by organizations such as the American Academy of Pediatrics and the National Center on Quality Assurance.

Specifically, the tool—which is tailored to elementary, middle, and high school centers—is a document that helps school-based health centers assess how well they care for students presenting with selected "Sentinel Conditions" as measured against published practice guidelines and recommendations. There are seven sentinel conditions for each of the three school age groups. The first condition measures how well centers do in providing students with a comprehensive annual health risk assessment and biannual physical exam, both of which are considered essential to detecting and addressing all important health concerns of students of every age. The remaining conditions include two mental health sentinel conditions. It is expected that sites will select only one of these to track. The other sentinel conditions represent the most commonly encountered and treatable health problems seen in school-based health centers. The seven sentinel conditions are not intended to be a comprehensive selection of all problems seen in a center, rather they are "core" conditions that most centers see on a regular basis and that they should have a lot of practice addressing.

"Our purpose isn't to drive centers crazy with a laundry list of 100 things or even 50 things that they must be doing right to get a passing grade," said developer Christopher Reif. "That would be asking too much, and centers wouldn't do it. Instead, we chose a limited number of sentinel conditions for each age group that we know everyone sees and that wouldn't overwhelm center staff, who already are stretched thin. I can't stress enough that we made a deliberate decision not to be comprehensive."

Tool is a "Fluid Method" not a "Static Document"

Part of the reason that the tool was not created to take a comprehensive measure of quality is that it is not intended to be a static document. "We hope that what we've created isn't just a tool but a fluid method," said developer Linda Juszczak. "It may be that five years from now, a different medical problem might replace one of the current sentinel conditions based on what the centers are seeing. Hopefully, there will be some way of having the tool constantly evaluated as to its usefulness and sensitivity."

According to Linda Juszczak, there are three important benefits to using this tool. First, most school-based health centers already find themselves doing some sort of quality documentation for their sponsoring organizations; this tool can standardize that process and make it a more valuable experience for everyone. Second, while other tools for assessing quality exist, this is the only tool that was tailor-made for school-based health centers and that specifically measures certain clinical conditions that school-based health centers are designed to detect and address. And third, if the tool is accepted by school-based health centers, it may become a standard in its own right—a way to establish national practice guidelines for school-based health centers.

The tool is currently being beta tested in 19 school-based health centers around the country, with the hope that it will be available for use in all school-based health centers by June. The federal Bureau of Primary Health Care (BPHC) is funding the beta test, which is being conducted by CHHCS.

"We're funding the beta test because we use federal dollars to support 78 school-based health centers through our Healthy Schools, Healthy Communities program. It's important that we're able to document the fact that our centers are effective in delivering medical care to children and adolescents," said LaVerne M. Green, RN, MA, director of BPHC's Center for School-Based Health Care. "We plan to disseminate the results of the beta test to all our grantees and encourage them to use the tool."

For now, school-based health centers that use the tool can compare their scores to their own previous scores (once they've established a baseline) as a way to document improvements or identify areas for further improvement. But the hope is that, eventually, a national database can be established that will enable centers to compare themselves to other centers, as well as provide national data on the efficacy and outcomes of school-based health centers.

An important player in the future of the CQI tool will be the National Assembly on School-Based Health Care. John Schlitt, director of the Assembly, serves on the national advisory committee that was formed to help guide the development of the tool and is very enthusiastic about its potential. "We certainly plan to do everything we can to facilitate further development of the tool and to encourage centers to use it. It will be tremendously beneficial to the field once people begin to use it," he said.

Continued from page 2

country: 4) resources and technical assistance to help develop and implement eight new centers; and 5) additional resources and focus on specific issues, such as the refining and shaping of center guidelines as well as the development of guidelines for the provision of mental health services and strategies for integration with managed care.

This is an exciting time for the state's centers, with unparalleled support from Governor Pataki, the state Department of Health, and localities. The centers currently receive over $18 million annually from state resources. The Department of Health has issued an RFA for over $11 million of these funds to support centers and expand services to include tobacco-use prevention projects and dental health services. New York has provided a fee-for-service carve out for services provided to children enrolled in Medicaid managed care and is exploring options to tap into Child Health Plus reimbursements. The Department of Health is working with the state Departments of Mental Health and Education to pool agency funding to support mental health clinics associated with school-based health centers. And a $4 million grant initiative is making funds available to the state's medical schools to support using centers as training sites for medical students/residents. A similar initiative is being planned for schools of dentistry, nursing, social work, and optometry.

NORTH CAROLINA
Marilyn Asay
In 1992 and 1993, the North Carolina General Assembly appropriated funds to establish 14 school-based and school-linked health centers with input from public and private entities. In 1995, RWJF awarded us an MTG grant to help convert our demonstration program into a statewide network of centers. Over the next few years, other foundations began supporting our growing network of over 50 school-based and school-linked health centers in 29 counties. Today, these centers are diverse in organization and sponsorship, but thanks to technical assistance from MTG, they all share the same purpose, build upon the same comprehensive service model, and are actively incorporating a standardized quality assurance component into their programs.

Since we knew our MTG grant funds were limited, we built a strong infrastructure for the provision of technical assistance and policy development. This translated into greater public awareness and support for our centers, including increased funding. Additional efforts to enhance the financial stability of our centers include a three-year grant from The Duke Endowment to develop and deliver technical assistance to local health centers. Along this same line, the Finance Committee of the State Coordinating Council worked to achieve reimbursement from NC's Medicaid and CHIP programs, and is meeting with managed care organizations to forge relationships that will benefit centers.

OREGON
Robert Nystrom
Our MTG grant provided an excellent opportunity for the 10-year-old Oregon School-Based Health Care Program to re-invent itself. This was accomplished by examining our model, building a data collection capacity, exploring financial sustainability issues, and developing educational and communication strategies. All of these efforts helped create a policy environment that embraced a 'best practices' partnership between local health departments, educational and other community partners, and state government. Highlights of our MTG experience have included establishing a state technical assistance office for school-based health centers, implementing state standards and a certification process, institutionalizing a statewide data collection effort, appropriating an additional $1 million in general funds for the 1999-2001 biennium, and forming a state chapter of the National Assembly.

The future holds more hard work for us: the centers have been identified for a budget cut – not from a lack of recognition of value, but because many good programs must compete for the same limited funds. Our examination of financial issues during the MTG period has impressed on us how fragile funding is at all levels. Regardless of this, we have still experienced steady growth in the number and quality of centers in Oregon over time, which says something to me. I'm confident that our local communities and legislative champions will speak to the importance of continued funding for the centers.

RHODE ISLAND
Rosemary Reilly-Chammat
MTG has brought resources and prestige to Rhode Island's school-based health center efforts. It provided resources to convene key stakeholders who have the interest and authority to move our centers from a pilot program into the mainstream health care system. Most recently, these efforts enabled the convening of a Special Senate Commission to Study School-Based Health Centers. The Commission's findings will help inform how the state can sustain our existing centers over the long term and build our capacity to support new centers in key areas. MTG has helped us link with states that are embarking on similar efforts and put our initiative within a national context. MTG has also been an important part of our efforts to inform policymakers about the unique needs of adolescents.

We anticipate that funding for our school-based health centers will last through the end of this school year. We are optimistic that the efforts of the Special Senate Commission and the Rhode Island Assembly on School Based Health Care will support core funding for all seven of our existing centers.

VERMONT
Dawn Chittenden
RWJF's MTG funds enabled us to open five school-based health centers in Vermont, bringing health care to students in rural communities where access and transportation are often problems. Without MTG, it is doubtful whether our centers would have been as successful as they have been in serving the numbers of students that they have, offering them both primary and mental health care. MTG has brought together people from various backgrounds, including health, education, and human services, to work collaboratively to promote school-based health centers in our state and improve outcomes for the children of Vermont.

Community members, parents, teachers, and students have enthusiastically embraced and supported the centers. During this last year, we have seen increased numbers of inquiries regarding school-based health centers, with more communities, school districts, and physicians realizing that there are benefits to offering medical and mental health care services at school.

www.healthinschools.org

The launch of the new Center for Health and Health Care in Schools means a new and expanded Web presence for the former Making the Grade site. Added features will include sections describing new ways of organizing and funding a variety of in-school health services and programs, several search features, and special sections on the new grant initiative and the CQI project. Data from Making the Grade's 2000 state survey of school-based health centers also will be posted. The popular monthly e-journal, *Health and Health Care in Schools*, will continue, and the papers and policy information you're accustomed to finding on the Making the Grade site also will be available.

Continued from page 1

The Foundation realized that creating another grant program to open 20 or 30 more school-based health centers wasn't going to push the envelope on a national scale. "We knew we had to address the problem of wide-scale replication," said Jellinek. "We had this great model and the demand was there, but we needed a way to get communities and states involved in creating their own, sustainable school-based health care programs." The result was Making the Grade: State and Local Partnerships to Establish School-Based Health Centers. Through Making the Grade (MTG), the Foundation funded nine states to both establish school-based health centers in local communities and create state and local policies that support the centers. The states were: Colorado, Connecticut, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island, and Vermont.

"Each of the nine grant states came into this program from different vantage points," said Lear. "New York was well-established, had a history of state funding support for school-based health centers, and already had a state membership association for the centers. Contrast that with Vermont, which didn't have a single center, or Rhode Island, which only had two. Each state had its own bar to move forward, so measuring their success is relative." (For details on the states' experiences, see "Parting Words..." on page 2).

RWJF's Jellinek sums up MTG this way: "In many Making the Grade states, there was more money available for school-based health centers at the end of the grant program than there was at the beginning. And beyond that, if you just look at the numbers of centers in those states today, the total is certainly much higher than if we had just done straight funding of a predetermined number of centers. There definitely has been a ripple effect—in Making the Grade states and beyond—but how much of one we can't be sure."

A New Resource

Regardless of how, when, or why they were created, in the 1999-2000 school year, there were nearly 1,400 school-based health centers in the United States serving an estimated 1.1 million children. MTG's funding stream has come to an end and rather than extend the grant program, RWJF has decided to help Julia Lear morph it into an entirely new entity: the Center for Health and Health Care in Schools.

"The Center is a logical extension of Making the Grade," said Jellinek. "Part of what Making the Grade did was play a technical assistance role for its grantees as well as other sites. In doing so, the national program office accumulated a lot of knowledge about school-based health centers. And in its later years, the office also began to look at the relationship between centers and some of the other important health promoting activities in schools. Sharing this information—as well as researching and sharing new information related to school health—is at the heart of the new Center."

Specifically, RWJF has committed $2.6 million over four years to help establish the Center, which plans to seek out additional sources of support as it moves forward. The Center will be based at The George Washington University and co-sponsored by its School of Public Health and Health Services and Graduate School of Education and Human Development. As noted previously, an early initiative of the Center will focus on expanding the capacity of centers to provide mental health and dental health services. RWJF has allocated about $3.4 million to support grants to school-based health centers interested in adding to or expanding mental health or dental services. A Call for Proposals describing the grant program will be issued this spring.

"The hope," said Julia Lear, "is that we will begin to see how school-based health centers can make a demonstrable impact on reducing the tremendous disparities in dental care and mental health care for kids in low-income and minority communities.

"I see the real goal of the Center as integrating health and health care programs in schools into the very fabric of how we think about securing good health outcomes for children," she said. "Whether the subject is attention deficit disorder, asthma management, depression, or nutrition, everyone who thinks about these topics ought to be thinking about where school fits in and what partnerships for prevention and service will secure the very best future possible for all our children."

SCHOOL-BASED HEALTH CENTERS IN MAKING THE GRADE STATES

	1994	1996	1998	2000
Colorado	26	28	3	33
Connecticut	32	51	51	56
Louisiana	9	16	30	40
Maryland	23	38	43	59
New York	146	149	158	159
North Carolina	20	30	39	41
Oregon	19	29	39	44
Rhode Island	2	3	4	7
Vermont	1	2	4	3
Total	278	346	371	442

Making the Grade is a national grant program supported by The Robert Wood Johnson Foundation. Under this initiative, the Foundation has funded nine states to establish school-based health centers in local communities and to create state and local policies that support comprehensive care for children and adolescents.

•••

Making the Grade

The George Washington University
School of Public Health and Health Services
1350 Connecticut Avenue, NW #505
Washington, DC 20036
Phone: 202-466-3396
Fax: 202-466-3467
E-mail: mtg@gwu.edu
Web site: www.gwu.edu/~mtg

Program Staff

Julia Graham Lear – Director
Nancy Eichner – Research Associate
Theresa Chapman – Office Manager

Editors: Burness Communications
Design: Len Ringel Graphic Design